COLORADO
Department of Health Care
Policy & Financing

Provider Web Portal Quick Guide - Verifying Member Eligibility (including Managed Care Assignment Details and Benefit Plan Information) and Co-Pay
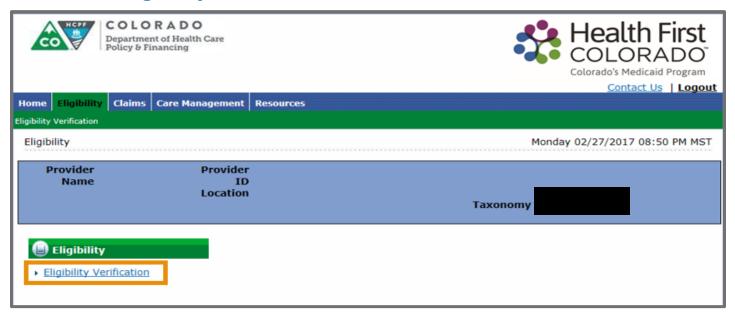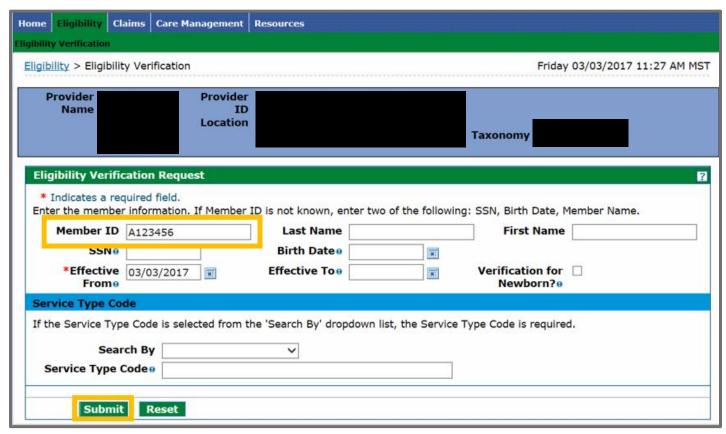
1. Log in to the Provider Web Portal.

2. Click the Eligibility tab.

3. Click the Eligibility Verification link.

4. Enter search criteria, then click "Submit."

5. Review the search results.

Member ID		Birth Date	Gender Female	
Coverage			**Effective Date**	**End Date**
Medicaid State Plan			08/01/2016	12/31/2299
Behavioral Health Benefits			08/01/2016	12/31/2299
HCBS Elderly, Blind, & Disabled Waiver			08/01/2016	12/31/2299
Qualified Medicare Beneficiary			09/01/2014	12/31/2299
Other Insurance Detail Information				

6. Click "Expand All" to view Benefit Details, Coverage, Co-payments and Managed Care Assignment Details.

The screenshot below shows Coverage Details, Benefit Details and Managed Care Assignment Details.

Coverage Details   **Back to Eligibility Verification**   ?

Coverage Details for Member ID ▆▆▆ – ▆▆▆▆▆▆ from 01/01/2014 to 12/31/2299

Eligibility Verification Response Guarantee Number ▆▆▆▆▆

Expand All | Collapse All

Benefit Details   —

Coverage	Description	Effective Date	End Date
TXIX	Medicaid State Plan - BJ	04/30/2018	04/30/2018
BHO+B	Behavioral Health Benefits - BJ	04/30/2018	04/30/2018

Coverage	Copayments	Amount
TXIX	Medical Care	$0.00
TXIX	Dental Care	$0.00
TXIX	Hospital	$0.00
TXIX	Hospital - Inpatient	$0.00
TXIX	Hospital - Outpatient	$0.00
TXIX	Emergency Services	$0.00
TXIX	Brand Name Prescription Drug	$0.00
TXIX	Generic Prescription Drug	$0.00
TXIX	Professional (Physician) Visit - Office	$0.00
TXIX	Vision (Optometry)	$0.00
TXIX	Mental Health	$0.00
TXIX	Urgent Care	$0.00
BHO+B	Hospital	$0.00
BHO+B	Hospital - Inpatient	$0.00
BHO+B	Hospital - Outpatient	$0.00
BHO+B	Emergency Services	$0.00
BHO+B	Professional (Physician) Visit - Office	$0.00
BHO+B	Mental Health	$0.00

Managed Care Assignment Details   —

Current MCO	Benefit Plan
ADAMS COUNTY SCHOOL DISTRICT 5	Primary Care Medical Provider
ROCKY MOUNTAIN HEALTH PLANS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

7. Verify member co-pay requirements by referring to the "Amount" column under the Benefit Details section.

Benefit Details   ▬

Coverage	Description	Effective Date	End Date
TXIX	Medicaid State Plan - HD	04/30/2018	04/30/2018
BHO+B	Behavioral Health Benefits - HD	04/30/2018	04/30/2018
ABP	Alternative Benefit Plan - HD	04/30/2018	04/30/2018

Coverage	Copayments	Amount
TXIX	Medical Care	$0.00
TXIX	Dental Care	$0.00
TXIX	Hospital	$0.00
TXIX	Hospital - Inpatient	$0.00
TXIX	Hospital - Outpatient	$0.00
TXIX	Emergency Services	$0.00
TXIX	Brand Name Prescription Drug	$0.00
TXIX	Generic Prescription Drug	$0.00
TXIX	Professional (Physician) Visit - Office	$0.00

The Department's co-pay policy has been updated. Some members may not be required to pay a co-pay for every visit, so it is important that providers check the co-pay amount every time they see a Health First Colorado member. If a member has already reached their 5% co-pay maximum for a given month, it will say "Member co-pay is exempt."

Scroll to the bottom of the page to see Managed Care Assignment Details.

8. If applicable, check the member's available units of physical/occupational therapy (PT/OT) services under the Limit Details section.
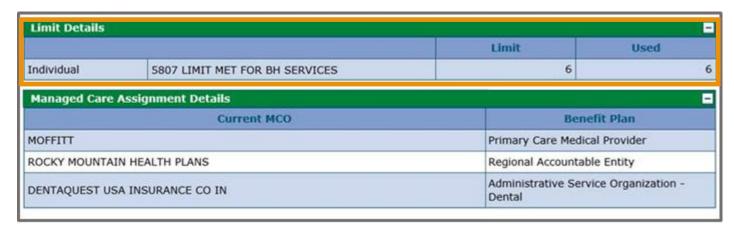
Benefit Details

Coverage	Description	Effective Date	End Date
QMB	Qualified Medicare Beneficiary - F4	08/16/2018	08/16/2018
EBD	HCBS Elderly, Blind, & Disabled Waiver - M8	08/16/2018	08/16/2018
TXIX	Medicaid State Plan - M8	08/16/2018	08/16/2018
BHO+B	Behavioral Health Benefits - M8	08/16/2018	08/16/2018

Coverage	Copayments	Amount
QMB	Medical Care	$0.00
QMB	Chiropractic	$0.00
QMB	Dental Care	$0.00

Limit Details

		Limit	Used
Individual	5500 PT & OT SVC LIMITS = 48/YR	48	6

Managed Care Assignment Details

Current MCO	Benefit Plan
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

This remaining benefit amount is calculated by counting all the paid units of service for PT/OT a member has incurred in the previous rolling 365 days. Once the soft limit of 48 units has been reached, an approved Prior Authorization Request (PAR) is required to exceed it.

The counting function will calculate PT/OT units regardless of whether they were paid with a PAR on file. This means that after a PAR for PT/OT is exhausted members will not automatically have another 48 units of PT/OT available without a PAR. A full 365 days must elapse before the member has another 48 units of PT/OT available without requiring a PAR.

Refer to the Benefit Limitation Frequently Asked Questions, located on the Outpatient PT/OT Benefits web page, for more information.

9. If applicable, check the member's available units of short-term behavioral health services under the Limit Details section.

Limit Details		Limit	Used
Individual	5807 LIMIT MET FOR BH SERVICES	6	6

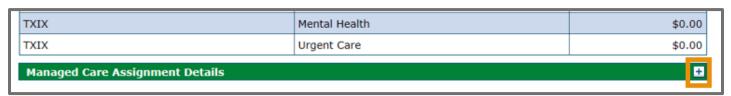| Managed Care Assignment Details	
Current MCO	**Benefit Plan**
MOFFITT	Primary Care Medical Provider
ROCKY MOUNTAIN HEALTH PLANS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

"5807 LIMIT MET FOR BH SERVICES" references the system audit that will post when the service unit limit is exceeded.
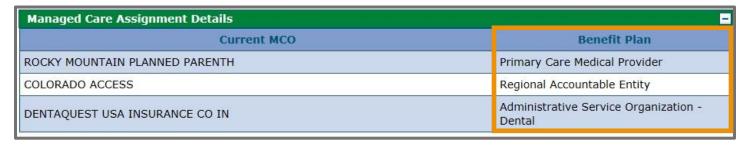
This used benefit amount is calculated by subtracting all the paid units of service for short-term behavioral health a member has incurred within the current state fiscal year from the limit. Once the unit limit has been reached for the state fiscal year, a PAR **cannot** be used to exceed it. Additional visits beyond the unit limit during a state fiscal year may be eligible for reimbursement by the Regional Accountable Entity in accordance with their provider credentialing and utilization management policies and procedures. At the beginning of the next state fiscal year, the total units for that fiscal year will be available.

10. Scroll to the Managed Care Assignment Details section, then click the [+] sign.

Click the plus [+] sign next to Managed Care Assignment Details.

TXIX	Mental Health	$0.00
TXIX	Urgent Care	$0.00
Managed Care Assignment Details		⊞

The program name under which the member is eligible will display under the Current MCO column. The benefit plan type for that particular program will display in the same row under the Benefit Plan column.

Managed Care Assignment Details	
Current MCO	**Benefit Plan**
ROCKY MOUNTAIN PLANNED PARENTH	Primary Care Medical Provider
COLORADO ACCESS	Regional Accountable Entity
DENTAQUEST USA INSURANCE CO IN	Administrative Service Organization - Dental

See the table below for a complete list of all possible benefit plans along with billing instructions and co-pay notes.
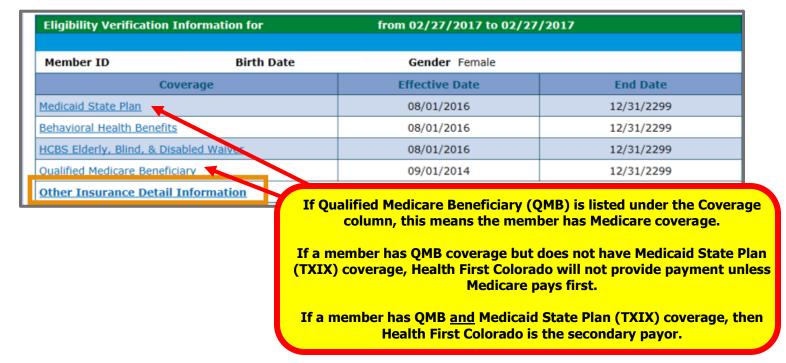
Benefit plans for which providers should bill DXC directly are marked in green below. Benefit plans for which providers should bill the listed Managed Care Organization are marked in red below.

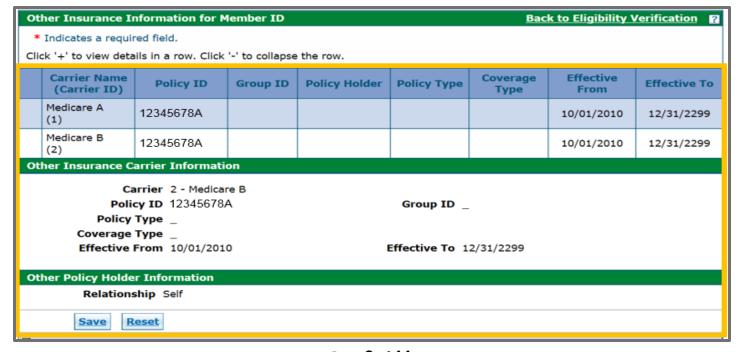| MC Benefit Plan	Billing	Co-pay
Denver Health Medicaid Choice (PIHP)	Providers should bill Denver Health directly, **not** DXC for medical claims. Mental health is billed to the RAE. Span must show "Active."	Most services, such as office visits, medications and hospital stays have co-pays. Services for pregnant women, children 18 and under, American Indians and Alaska Natives do not require a co-pay.
Denver Health and Hospital Authority - Primary Care Medical Provider	Providers should **not** bill the PCMP and instead should bill DXC directly for medical claims. Mental health is billed to the RAE.	Not applicable
Rocky Mountain Health Plans	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly.	
Rocky Mountain Health Plans Prime	Providers should bill Rocky Mountain Health Plans Prime directly, **not** DXC. Mental health should be billed to the RAE.	Contact Rocky Mountain Health Plans Prime for co-pay details.
Accountable Care Collaborative	Providers should **not** bill the ACC, PCMP or RCCO and instead should bill DXC Technology (DXC) directly (unless the services are for mental health). **Note:** ACC will only appear for dates of service prior to 7/1/18.	Not applicable
Administrative Service Organization - Dental	Providers should bill DentaQuest directly, **not** DXC.	Contact DentaQuest for co-pay details.
Child Health Plan *Plus* or **Child Health Plan *Plus* - Dental** or **State Managed Care Network - CHP+**	Providers should bill Child Health Plan *Plus* (CHP+) directly, **not** DXC.	Some CHP+ clients may also have to pay co-pays to their health care provider at the time of service. There are no co-pays for preventative care, such as prenatal care and check-ups. Other services may require co-pays based on member income. Native Americans and Alaskan Natives do not have to pay co-pays.
Primary Care Medical Provider	Providers should **not** bill the RAE or PCMP and instead should bill DXC directly for medical claims. Mental health should be billed to the RAE.	Not applicable
Program For All-Inclusive Care For The Elderly	Providers should bill the Program of All-Inclusive Care for the Elderly (PACE) directly, **not** DXC.	There are no co-payments or out-of-pocket expenses for services covered under this program.
Regional Accountable Entity *[formerly known as Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs)]*	Providers should bill the RAE for mental health services (behavioral therapy is an exception). Medical claims should be billed to DXC directly, unless they have Denver Health PHIP or Rocky Mountain Prime.	There are no co-pays for Health First Colorado behavioral health services. However, if the member has other insurance, they must use that insurance first before using Health First Colorado benefits.

11. To see Third Party Liability (TPL) coverage (including Medicare), return to the Eligibility Verification page.

Home	Eligibility	Claims	Care Management	Resources

Eligibility Verification

Eligibility > Eligibility Verification > Coverage Details   Monday 02/27/2017 09:35 PM MST

12. Scroll to bottom of page and click "Other Insurance Detail Information."

Eligibility Verification Information for	from 02/27/2017 to 02/27/2017	

Member ID	Birth Date	Gender Female	

Coverage	Effective Date	End Date
Medicaid State Plan	08/01/2016	12/31/2299
Behavioral Health Benefits	08/01/2016	12/31/2299
HCBS Elderly, Blind, & Disabled Waiver	08/01/2016	12/31/2299
Qualified Medicare Beneficiary	09/01/2014	12/31/2299
Other Insurance Detail Information		

If Qualified Medicare Beneficiary (QMB) is listed under the Coverage column, this means the member has Medicare coverage.

If a member has QMB coverage but does not have Medicaid State Plan (TXIX) coverage, Health First Colorado will not provide payment unless Medicare pays first.

If a member has QMB **and** Medicaid State Plan (TXIX) coverage, then Health First Colorado is the secondary payor.

This is where other insurance coverage (including Medicare coverage) is displayed:

Other Insurance Information for Member ID   **Back to Eligibility Verification** [?]

* Indicates a required field.

Click '+' to view details in a row. Click '-' to collapse the row.

Carrier Name (Carrier ID)	Policy ID	Group ID	Policy Holder	Policy Type	Coverage Type	Effective From	Effective To
Medicare A (1)	12345678A					10/01/2010	12/31/2299
Medicare B (2)	12345678A					10/01/2010	12/31/2299

Other Insurance Carrier Information

Carrier 2 - Medicare B
Policy ID 12345678A   Group ID _
Policy Type _
Coverage Type _
Effective From 10/01/2010   Effective To 12/31/2299

Other Policy Holder Information

Relationship Self

Save	Reset

13. Add additional TPL information as needed.

Refer to the Updating Additional TPL Information Provider Web Portal Quick Guide for step-by-step instructions on how to add TPL information for a member with TPL coverage that isn't already listed.

Need More Help?

Please visit the Quick Guides and Webinars web page to find all the Provider Web Portal Quick Guides:

Aid Code and Benefit Plan Acronyms	**Reading the Remittance Advice (RA) Dated on or After 1/9/2019**
Adding and Updating TPL Information	**Submitting a Claim with Other Insurance or Medicare Crossover Information**
Are You Billing from the Correct Account?	**Submitting an Institutional Claim**
Copy, Adjust, or Void a Claim	**Submitting a Professional Claim**
Delegates	**Validating a Trading Partner ID (TPID)**
Delegate Access Definitions	**Verifying Member Eligibility and Co-Pay**
Entering Third Party Liability	• Managed Care Assignments
Provider Maintenance	• Primary Care Provider
Provider Maintenance – License Update	• Medicare Coverage
	• Member Co-Pay Amounts
Pulling your 835 - Linking to your own TPID	**Updating your EFT Information**
Pulling your Remittance Advice (RA)	**Updating your ERA Information**
Reading the Remittance Advice (RA) Dated Before 1/9/2019	**Viewing Prior Authorizations in the Portal**
	Web Portal Registration
• Internal Control Number (ICN) Information Sheet	
• Region Code Information Sheet	

Provider Web Portal – Frequently Asked Questions (FAQs)

Please visit the Provider FAQ Central web page and look under the Billing and Web Portal headings to see Provider Web Portal FAQs.

Provider Web Portal – Recorded Webinars
Click the links below to access the recorded webinars:

Session #1   Access the new Portal, Portal Registration, Log in, My Profile, Manage Accounts (including delegates)

Session #2   Provider Maintenance (including updates and affiliations), EFT/ERA Enrollment, Disenrollment

Session #3   Member Information and Eligibility Verification

Session #4   Remittance Advice (RA), Search Payment History, Search for Accounts Receivable Records, Make a Payment

Session #5   Notify Me, Alerts, Secure Correspondence

Session #6   Files Exchange, Resources

Session #7   Search & Submit CMS 1500, UB-04, Emergency Dental Claims, Prior Authorizations (Nursing Facility PETI PARs only)

Bridge   Bridge training for Community Centered Boards (CCBs) only